The Foundation of Cancer Specialists

d/b/a The Patient Assistance Foundation

Grantmaking Guidelines

The mission of The Foundation of Cancer Specialists is to ease the financial burden of patients in our community who are suffering from cancer or malignant blood-related diseases.

SECTION I: Foundation Purpose:

To provide short-term financial assistance for, as an example, but not limited to:

- Rent or mortgage payments
- Basic utilities, including water, sewer, electricity, or telephone
- Basic transportation costs, including car payments and/or repairs
- Car, home, or renter's insurance expenses

All payments are made out directly to the payee. The Foundation never pays patients directly

The Foundation does not pay patient medical bills, copayments, internet/tv, or credit card bills

SECTION II: Eligibility Guidelines: *PLEASE READ CAREFULLY*

To qualify for a Foundation Grant, the patient must:

- Be 18 years of age or older
- Be a current resident of one of the following counties in North Florida or South Georgia:
  - Baker (FL)
  - Clay (FL)
  - Duval (FL)
  - Flagler (FL)
  - Nassau (FL)
  - Putman (FL)
  - St. John's (FL)
  - Camden (GA)
  - Charlton (GA)
- Have received treatment from an oncologist or hematologist for cancer or malignant blood-related diseases within the past 3 months.
  - Treatment is defined as receiving blood products, chemotherapy, radiation, and/or surgery
- Have a monthly income at or below 300% of the national poverty level
- Have no more than $10,000 in liquid assets
  - Liquid assets are defined as cash, checking or savings accounts, stocks, bonds, etc.
- Have no more than $50,000 in a 401K, IRA, or other comparable retirement savings accounts.
- Disclose all property owned, businesses, and rentals. This will be considered in making our final decision.
- Disclose all assistance previously received. This will be considered in making our final decision.

SECTION III: 2026 Federal Poverty Guidelines: *PLEASE READ CAREFULLY*

# in Household	300% of Poverty Level	300% of Monthly Poverty Level
1	$47,880	$3,990
2	$64,920	$5,410
3	$81,960	$6,830
4	$99,000	$8,250
5	$116,040	$9,670
6	$133,080	$11,090
7	$150,120	$12,510
8	$167,160	$13,930

SECTION IV: Grant Award Amounts

- For debt incurred within the past 12 months that was incurred as a direct result of the illness
- For patients currently in active treatment
    - Debt above **$200** and below **$3,000**, pending available funding
- For patients who have completed treatment within the past 3 months:
    - Debt above **$200** and below **$1,500**, pending available funding
- Submitted no more than once per patient, unless there is a significant change of status based solely on diagnosis and no more than one time per 6-month period as specified in **Section IX.**
    - Maximum grant amount to be determined by the Application Review Committee

SECTION V: Application Process: *PLEASE READ CAREFULLY*

Patients must fully complete and sign the ***Grant Application***, ***Personal Statement & Bill Request, and Proof of Diagnosis*** form.

In addition, the following documentation is **required at the time of submission** for applications to be considered:

- Current photocopies of bills and/or invoices to be paid
- Photocopies of the last 3 months of bank and/or brokerage statements for all open accounts of household members.
    - Please note that all bank statements are subject to comprehensive analysis by the Application Review Committee (ARC). ARC reserves the right to request additional information based on this analysis which may factor in approval or denial of application.
- Photocopies of most recent Federal Income Tax Return
- Photocopies of W2 for all household members of working age
- Photocopies of last 3 paystubs
- Social Security and/or Disability award letters/statements for patient and all household members, if applicable
- Any other applicable income for all household members of working age for the last 3 months, including, **but not limited to**, alimony, child support, money transfers/assistance from **non-household members**.
- Full disclosure and copies of statements for 401Ks, IRAs, HSAs, HRAs, FSAs, stocks, bonds, and any other monetary assets
- Full disclosure of any other grants received from other charitable organizations within the last 12 months.

If you are unable to provide any of the above information, please explain why under the "Additional Information" section locations on the **Personal Statement & Bill Request form**

SECTION VI: Review Process

- The applicant must submit a completed application, and all required supporting documentation, as outlined in Section V, to The Foundation.
- The ARC will document the date of its initial review of the application.
    - This date will initiate the 30-day submission period for the applicant to submit any outstanding required documentation
- The ARC will review applications and notify applicants in writing if additional documentation is required. The ARC will continue to communicate requests for outstanding documentation until all required documentation has been received or the 30-day submission period has expired.
- Failure to submit all requested documentation within the 30-day period specified in the request for additional information letter will result in automatic denial of the application.
    - The Board of Directors reserves the right to extend 30-day submission period based on extenuating circumstances; such extension requires simple majority.
- The ARC will communicate directly with applicants in writing regarding application status and determinations, including requests for additional information, approvals, and denials. **All decisions are final.**

SECTION VII: Application Timeline Expectations

- **Application Submission to Initial Review:** Up to two weeks.
- **Final Documentation Collection to Application Approval:** Up to two weeks.
- **Application Approval to Check Mailing:** Up to two weeks.
- **Check Mailing to Account Credit:** Up to one month.

These timelines represent estimated maximum processing periods and may vary depending on the completeness of the application, processing requirements, and the applicant's financial institution.

SECTION VIII: Discretionary Foundation Guidelines:

- Exceptions to the Foundation Guidelines listed previously are possible only with the approval of the Foundation Board of Directors in a simple majority vote.
- Grant requests that fall outside the eligibility criteria outlined in **Section II** remain subject to the applicable requirements and limitations established in these guidelines, unless otherwise approved by the Foundation Board of Directors.

SECTION IX: Additional Provisions

1. **Application Review Authority**
    a. Application decisions will be made by the Application Review Committee (ARC) in accordance with the Foundation's established guidelines and under the authority delegated by the Board of Directors.
2. **Subsequent Applications**
    a. In keeping with the Foundation's mission to provide short-term emergency financial assistance, patients who have previously received assistance are eligible to reapply **only if** they have received a **new primary cancer diagnosis or experienced a one-time progression of metastatic disease.** Additionally, at least six months must have elapsed from the date of their initial application approval before a subsequent application may be submitted.
3. **Application Documentation**
    a. Applicants must submit a completed application along with all required supporting documentation to be considered for assistance. If additional documentation is needed, the Application Review Committee (ARC) will notify the applicant in writing. Applicants will have 30 days from the date of the ARC's initial review to submit all outstanding documentation.
4. **Denial Due to Incomplete Application**
    a. Applicants whose applications are denied due to failure to submit required documentation or otherwise failing to meet application completion requirements must wait **three months from the date of denial** before reapplying, unless an exception is approved by a simple majority vote of the Foundation Board of Directors.
    b. An incomplete application includes, but is not limited to, missing required documentation, failure to obtain the applicant's signature, or failure to complete all required sections of the application. The ARC, acting under the authority delegated by the Foundation Board of Directors, reserves the right to determine whether an application is considered incomplete
5. **Denial Due to Failure to Meet Eligibility Guidelines**
    a. Applicants whose applications are denied for failure to meet the Foundation's established eligibility criteria as outlined in **Section II** must wait six months from the date of denial before reapplying, unless an exception is approved by a simple majority vote of the Foundation Board of Directors.
6. **Submission of False or Misleading Information**
    a. Applicants denied due to the submission of false or misleading information may be **deemed ineligible to reapply**, subject to review and determination by the Foundation Board of Directors.

The Foundation of Cancer Specialists
Support Through Treatment

*THIS FORM MUST BE FULLY COMPLETED AND RETURNED WITH ALL SUPPORTING DOCUMENTATION OR APPLICATION ***WILL NOT BE CONSIDERED****

FINANCIAL INTERVIEW

Oncology Group: _____

Patient Information:

Patient Name: _____

Last Four SS #: _____ **Date of Birth:** _____ **Phone:** _____

Address: _____

_____ **#Living in Household:** _____

Monthly Income:

Monthly Net Earnings (Self): $ _____

Monthly Net Earnings (Partner/Spouse): $ _____

Alimony, *if applicable:* $ _____

Child Support, *if applicable:* $ _____

Family/Friend Support, *if applicable*: $ _____

Any Additional Income, *if applicable*: $ _____

Explain Additional Income:

_____

_____

TOTAL NET MONTHLY HOUSEHOLD INCOME: $_____

Total Assets:

Do you own property other than your primary residence? Yes: _____ No: _____

Do you have a savings account? Yes: _____ No: _____

Do you have any type of retirement accounts? Yes: _____ No: _____

Please list the current totals in the following accounts. If not applicable, write "N/A"

Checking: $ _____ **Savings:** $ _____ **Retirement:** $ _____ **Stocks/Bonds:** $ _____

Additional Assistance Disclosure:

Have you received assistance in the past 12 months from any other charitable organizations, churches, etc.? Yes: ___ No: ___

Organization	Amount

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PERSONAL STATEMENT

Please answer the following questions fully and to the best of your ability.
If you do not have an answer or the question does not apply to you, please write "N/A".

1. **Explain the impact your medical diagnosis has had on your ability to pay bills:**

_____

_____

_____

_____

2. **Understanding this assistance is only short term, what long-term steps do you have in place to resolve this financial burden?**

_____

_____

_____

_____

3. **Are there any documents or missing information from this application?**

_____

_____

_____

_____

4. **Is there any other information you would like the Application Review Committee to know?**

_____

_____

_____

_____

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Support Through Treatment

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BILL REQUEST FORM

Please identify the three bills for which you are most in need of financial assistance.
Please indicate who checks should be made out to.

Rent or Mortgage: _____
Monthly Amount: _____
Payment address: _____
_____
_____
Account number: _____
W9 for Private Payee: _____

Cell Phone: _____
Monthly Amount: _____
Payment address: _____
_____
_____
Account number: _____

Home Insurance:
Monthly Amount: _____
Payment address: _____
_____
_____
Account number: _____

Utilities: _____
Monthly Amount: _____
Payment address: _____
_____
_____
Account number: _____

Auto Loan:
Monthly Amount: _____
Payment address: _____
_____
_____
Account number: _____

Other: _____
Monthly Amount: _____
Payment address: _____
_____
_____
Account number: _____

Auto Insurance: _____
Monthly Amount: _____
Payment address: _____
_____
_____
Account number: _____

Other: _____
Monthly Amount: _____
Payment address: _____
_____
_____
Account number: _____

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Support Through Treatment

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PROOF OF DIAGNOSIS

Patient Information:

Patient Name: _____

Last 4 Digits of Social Security Number: _____ **Date of Birth:** _____

Physician/Oncologist Information:

Name of Treatment Center: _____ **Name of Physician:** _____

Address of Treatment Center: _____

Phone Number: _____ **Name of Social Worker/Case Manager:** _____

Diagnosis Information:

Cancer Diagnosis: _____ **Date of Diagnosis:** _____

Has the patient undergone surgery for cancer? Yes: _____ No: _____ If Yes, Date of Surgery: _____

Treatment Information:

Is the patient listed above currently undergoing active cancer treatment? Yes: _____ No: _____

If yes, please complete the following:

Current Treatment: Chemotherapy: _____ Immunotherapy: _____ Radiation: _____ Other: _____

Drug Name: _____ **Start Date:** _____ **Projected End Date:** _____

Radiation Treatment: _____ **Start Date:** _____ **Projected End Date:** _____

If no, please complete the following:

Date of Last Treatment: _____ **Type of Treatment:** _____

Social Worker/Case Manager Signature: _____ **Date:** _____

Patient Signature: _____ **Date:** _____

Patients must sign their own application, unless someone has been appointed as medical proxy.

The Foundation of Cancer Specialists
Support Through Treatment

THIS FORM MUST BE FULLY COMPLETED AND RETURNED WITH ALL SUPPORTING DOCUMENTATION OR APPLICATION *WILL NOT BE CONSIDERED

APPLICATION STATEMENT

Please sign and initial all designated areas throughout this page to acknowledge that you have read, understand, and agree to the information, policies, and requirements outlined.

1. I certify that all the information that I have provided in order to apply for financial assistance is true, complete and correct.

_____
Initials

2. I expressly authorize, without reservation, The Foundation of Cancer Specialists d/b/a The Patient Assistance Foundation and its advisors or representatives to contact and obtain information from all employers, physicians, related creditors, and public agencies and to otherwise verify the accuracy of all information provided by me in this application, or financial interview.

_____
Initials

3. I hereby waive any and all rights and claims I may have regarding The Foundation of Cancer Specialists d/b/a The Patient Assistance Foundation and its advisors or representatives for seeking, gathering and using truthful and no-defamatory information, in a lawful manner, in the application process and all other persons, corporations or organizations for furnishing such information about me.

_____
Initials

4. I agree that I have received a copy of and fully understand The Foundation of Cancer Specialists d/b/a The Patient Assistance Foundation guidelines as written on Pages 1 – 3 of this application.

_____
Initials

5. I understand that any information provided by me that is found to be false, incomplete or misrepresented in any respect will be sufficient cause to (i) eliminate me from consideration for financial assistance, and (ii) will result in the immediate denial of this application.

_____
Initials

6. I understand and agree that meeting the eligibility guidelines as outlined in **Section II** does not guarantee approval of and distribution of grant.

_____
Initials

OPTIONAL: By initialing below, I am indicating that someone else completed this application on my behalf. I have reviewed information they have provided and agree that is a true and factual representation of what I would like to share with The Foundation regarding my current situation.

_____
Initials

Please indicate which form of communication you prefer: Mail: _____ Email: _____

If you selected email, please write it here: _____

By signing below, I certify that I have read, fully understand, and agree to all terms and conditions outlined in this application and the Foundation's Grantmaking Guidelines. I acknowledge and agree to comply with all requirements and parameters established by the Foundation. I further understand and acknowledge that all decisions made by the Application Review Committee are final.

Signature: _____ **Date**: _____

Patients must sign their own application, unless someone has been appointed as medical proxy.

Application Submission:

Please return completed application to your oncology social worker.

Only fully completed applications with all supporting documents as outlined on pages 1 and 2 will be processed.

Social Workers: Please submit completed applications using one of the following methods:

Mail
Patient Assistance Foundation
Attn: Karen Berman
7751 Belfort Pkwy
Suite 350
Jacksonville, FL 32256

Email:
Cancer Specialists of North Florida applicants:
foundation@CSNF.us

All other applicants:
pafcsnf@CSNF.us

Gift Card and Check Distribution:

Patients may be approved for gas and grocery gift cards or would prefer to pick up a rent check.

Gift cards and rent checks can be obtained in one of the following ways:

1. Patients may pick up gift cards at 7751 Belfort Pkwy, Suite 350, Jacksonville, FL 32256, on Wednesdays and/or Fridays from 8:00 a.m. to 11:00 a.m.

2. Approved patients' treatment centers may cover the cost of courier delivery from the Foundation's office at 7751 Belfort Pkwy, Suite 350, Jacksonville, FL 32256, to their office.
   a. Gift cards and/or rent checks must be received by the patients' social worker.
   b. The signed Acknowledgment Receipt Sheet must be returned to the Foundation's office by courier.

Once gift cards and/or rent checks have been distributed, the social worker must scan and email the signed gift card receipt form to the appropriate email as listed above.

The following should be noted:

- Gift cards cannot be mailed
- Patients will be notified via mail of their approval